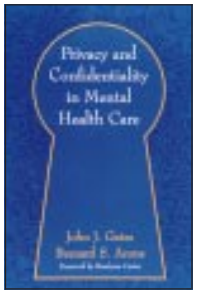
reviews

BOOKS • CD ROMS • ART • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS • MINERVA

Privacy and Confidentiality in Mental Health Care

Eds John J Gates, Bernard S Arons



P H Brookes, £27.50, pp 272
ISBN 1 55766 426 9

Rating: ★★★

Gates and Arons discuss issues of confidentiality and privacy in the United States in relation to mental health services for adults and children, law and ethics, technology, substance misuse, and the patient's family. One is left with the impression that there is no uniform "protection under the law" regarding the privacy and confidentiality of mental health records in the United States. Laws guaranteeing privacy and confidentiality vary from state to state, with some states having no guarantees. Protection under federal law is sparse.

Indeed, Gates and Arons present evidence that privacy and confidentiality are compromised because of bureaucratic lack of security and respect for patients' data, misguided corporate invasions of privacy, and unchallenged claims for "a need to know" by school systems, employers, municipalities, and insurance companies. The retrieval, transmission, and analysis of these data have become a big business, which has led to questions about proprietorship and control of data.

The authors consider how informed consent has been used by managed care companies as a form of coercion. If a US patient refuses to give consent the company may refuse to pay for healthcare services. Gates and Arons recognise the benefits of the electronic medical record, but also the potential security hazards from misdirected electronic transmissions: within seconds, thousands of records can be stolen, corrupted, or lost. The authors also address how changes in confidentiality and privacy within the mental health system have affected the psychotherapeutic process and the quality of care of those with mental illness.

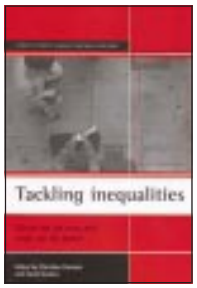
Although the book argues that there is often inadequate attention to confidentiality and privacy, it also suggests that confidentiality can be misused. For example, the authors suggest that the families of mentally ill patients are deliberately denied access to information about patients, and they aren't given adequate education on how to care for their sick relatives, all in the name of "protecting confidentiality." As a result, they argue, family members become frustrated, distressed, and bewildered.

Gates and Arons have brilliantly outlined the failure in the United States to protect confidentiality and privacy, and they provide suggestions for change and improvement. The text is well researched, and it balances the various social and legal issues involved.

Carmine U Iacono *psychologist research coordinator, Memorial Family Practice Residency Program, Houston, USA*

Tackling Inequalities: Where are we now and what can be done?

Eds C Pantazis, D Gordon



Policy Press, £15.99, pp 250
ISBN 1 86134 146 6

Rating: ★★★

Hot on the heels of evidence based medicine comes evidence based health policy, with a proliferation of articles and journals and the birth of academic centres and review facilities. Advocates of this movement cite a sizeable body of research that might inform or even determine policy and press for randomised trials of health policy interventions. Others argue that the current evidence base is wholly insufficient and that a wider range of methodologies needs to be considered. Evidence based policy has become a Holy Grail.

But not all evidence is holy, pure, or perfect. It can be interpreted in different ways, depending not only on its content and method but also on the values and beliefs of the interpreter. The editors of *Tackling Inequalities* are refreshingly frank in setting out their political and scientific values. They see their role as campaigning rather than simply academic. Paraphrasing the old Marxist adage, they say that "the purpose of statistics … is not only to describe the world but also to change it."

The current government favours area based initiatives, like health and education action zones. Many of the book's authors note that basing policy on statistics collected at area level risks incurring the "ecological fallacy"—associations between variables at an aggregate level do not necessarily mean that the association exists at the level of an individual. A classic example is the (now discounted) link between hardness of drinking water and mortality from heart disease, which was based on area level analysis and not the exposures and deaths of individual people. Furthermore, area based approaches reach only a minority of poor people, most of whom do not live in poor areas, and benefit people who are not poor but who live in areas that are. On this evidence many of the authors advocate, in some form or another, policies based on income redistribution at the individual level.

Although the focus of the book is inequality per se rather than inequalities in health, there is much to interest doctors, both personally and professionally. For example, the chapter on income inequality explores issues of wealth as well as poverty. In an examination of criminal and social harm we find that poor people are more fearful than rich people of being the victims of personal violence, but they are also more afraid of other adverse events such as job loss and debt. Topping all of these, the commonest fear is of illness.

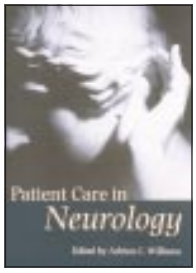
The authors take the government to task for doing too little to reduce inequalities. Whether you like this book will depend partly on whether you like this government. But it is difficult to remain unmoved by the stark contrasts between the haves and have-nots in our society.

Catherine Law *epidemiologist, MRC Environmental Epidemiology Unit, University of Southampton*

Reviews are rated on a 4 star scale (4=excellent)

Patient Care in Neurology

Ed Adrian C Williams



Oxford University Press, £35, pp 500
ISBN 0 19 262857 7

Rating: ★★

The neurology section in medical libraries tends to consist of weighty tomes that are standard texts for the specialist and a motley selection of layperson's guides on how to cope with neurological disability. Nothing wrong with either, but there is surely room for a meeting of minds in the approach to neurological practice.

Patient Care in Neurology is written for neurologists, but its strategy is to broaden the debate from the narrow standpoint of diagnosis to the broader issue of how you actually look after patients. This refreshing approach reflects the changing attitude of neurologists to their role in treatment and in communicating their expertise to patients, general practitioners, and specialists in other branches of medicine.

The end result is something of a curate's egg. The interesting chapters are ones that are conspicuously absent from standard textbooks and which form an innovative contribution. The subject matter here includes specific problems in elderly people, the neurological problems of ethnic minorities, and a brave chapter on dying from a neurological disorder. A further broadening is provided by discussion of a team approach to the management of neurological disease and consideration of how neurologists link with lay societies. Medical education is also considered in an excellent chapter, which begins with the masterly understatement that it is easy to underestimate the value of patients in the learning of clinical neurology.

An attempt has also been made to include a wide ranging discussion of how neurological services should be organised. This includes rather complicated chapters about the current structure and management of the NHS. This aspect of the book is less successful, partly because much of the debate is political history but also because it would in any event appeal to only a relatively small band of neurologists in Britain. Those from Europe or the United States would be mystified by such issues if they bothered to read about them, and this does limit the market for the book.

Beyond the unusual, the text encompasses several specific neurological conditions in a fairly straightforward and standard fashion. There is some variability, in that a few topics are considered in exhaustive review whereas others merit only a short contribution.

I was left with the feeling that *Patient Care in Neurology* is a brave attempt to market the specialty, but I wonder whether it will appeal to the broad audience at which it is presumably aimed. None the less, it is a step forward and will stimulate debate about the emergence of neurology from the closet of esoteric and untreatable syndromes.

N F Lawton *consultant neurologist, Wessex Neurological Centre, Southampton*

Some Mother's Daughter: the Hidden Movement of Prostitute Women Against Violence

See also p 524

International Prostitutes Collective (ed Nina Lopez-Jones)

Crossroads Books, £8, pp 180
ISBN 0 951 7775 8 X

Rating: ★★★

Vice girl, social pariah, the victim who "asks for it"—these are some of the stereotypes about prostitutes. Rape, beatings, and abuse are often seen as inevitable, almost justified, hazards of "the lifestyle." The murder of at least six prostitutes in Glasgow over the past nine years has been met with a resounding silence. Their deaths are not deemed worthy of major news coverage. Only when "ordinary" women are attacked does such violence become noteworthy.

This is not new. When the Yorkshire Ripper, an English serial killer, was terrorising women in northern England the media distinguished between prostitutes and "innocent" victims. The attorney general declared that "perhaps the saddest part of this case is that . . . the last six attacks were on totally respectable women." After one of the murders, the police warned that the next victim could be "somebody's daughter," as if the murdered prostitutes were not part of anybody's family.

This collection of short essays, protest leaflets, and accounts of activism from the International Prostitutes Collective presents a robust challenge to such prejudice. It highlights the extent of violence against prostitutes, documents campaigns for their rights, and analyses the negative impact of poverty, racism, and the action of the police and courts. When possession of condoms is taken as evidence of sex work it operates against safer sexual practices. Laws against brothels inhibit women from providing mutual support in shared premises. Prostitutes who report being raped find that their sexual histories are used against them in court. Immigration legislation can trap women into sexual slavery. The collective argues that most of the specialised laws around prostitution and pimping demean and even reinforce violence against prostitutes. Why, for example, should the police not simply enforce existing laws against kidnapping, blackmail, and fraud regardless of the victim's status as a sex worker?

The section on community responses to red light areas draws critical attention to how we define "community" interests and acceptable vigilante action. The chapter based on an interview with a member of the San Francisco Task Force on Prostitution examines potential strategies and draws distinctions between different policy options. For example, it discusses decriminalisation, legalisation, and zoning—supporting the first option but opposing the latter two on the grounds that they will be used to control women.

Less satisfactory are the collective's references to divisions between feminist activists in this field. The contributors are highly critical of "anti-porn feminists" and those who run programmes designed to challenge the attitudes of men who use prostitutes. Such campaigners are accused of attacking prostitutes rather than the sex industry and of portraying clients, and indeed sex industry workers, as sexual "perverts." This does not do justice to the current thoughtful and impassioned debates within feminism about the implications of selling or buying sexual services. It also ignores the vital work done by feminists, including prostitutes, who believe that harm reduction tactics in isolation end up colluding with a destructive culture and that it is possible, indeed necessary, to be anti-prostitution without being anti-prostitute.

Overall, however, this book is a lively and useful introduction to the multiple obstacles to prostitutes' rights and safety. It is a concise and inspiring record of the work by some women prostitutes to "strengthen the position of all women in the industry to defend ourselves against rape and violence, against exploitation by pimps and employers and attacks from the police." The urgency of this work cannot be denied. As I write this review, yet another woman in Glasgow has been attacked and is currently in intensive care.

Jenny Kitzinger *director, Centre for Media and Communications Research, Brunel University, Uxbridge*

Blunders will never cease

How the media report medical errors

On the front page of London's *Evening Standard* of 14 February the face of 3 year old Najiyah Hussain, beside the headline "She was killed by a hospital," looks the epitome of wronged innocence. The paper's principal focus is the human tragedy of Najiyah and of her family. There has been little time, and little space, for analysis. But we are told: "Police are investigating the incident and a doctor has been suspended."

The facts seem obvious. Najiyah, "given laughing gas instead of oxygen," was the victim of a mistake that you would not expect could happen in a modern health service. A victim, just like Wayne Jowett, who died on 2 February, a month after vincristine was injected into his spine instead of a vein at Queen's Medical Centre, Nottingham. And just like the 74 year old man who died at the Royal Sussex County Hospital, Brighton, after the wrong drug was administered during surgery on 7 February.

Yet mistakes of the kind that led to such deaths are not as rare as the public believes. It is just that, by focusing—as newspapers and other popular media almost invariably do—on the human tragedy of the victims and notions of individual culpability, the extent of errors and the system failures responsible are overlooked. The *Daily Mail*'s first report on the death of Najiyah Hussain was: "Doctor may face gas death charge." Lower down the story mentions that safety procedures are meant to ensure that nitrous oxide cannot be confused with oxygen, but the finger has already been pointed.

In all this there is an assumption that doctors generally don't make mistakes, and those who do have failed to live up to some imagined medical paragon. But is there a point in the reporting of errors at which the volume of cases will lead away from a focus on individuals to an acceptance that mistakes are inevitable in any system operated by humans and that there is a need for a system based rather than a blame based approach? In this respect, Alison Harper's following account of how she covered two incidents in Brighton offers some hope.

Trevor Jackson *BMJ*

A risky business

"Nothing is 100% foolproof, health care is a risky business. We have to recognise that it's given by people and not machines and people do make mistakes," Stuart Welling, chief executive of Brighton Health Care NHS Trust, told BBC Southern Counties Radio on 14 February:

He was speaking less than a week after an elderly patient had died after being given the wrong drug in an emergency procedure, less than 48 hours after a local surgeon had publicly claimed that mistakes were happening on a daily basis in Sussex hospitals, and on the day that the trust admitted that a child with suspected meningitis had been moved to a London hospital after being given four times the correct dose of an antiviral drug. Not a good week for him and not a good week for the reputation of health care in the area.

It started with an elderly man dying in intensive care at the Royal Sussex County Hospital in Brighton five days after being given the wrong drug during an operation for an abdominal aortic aneurysm. It was this case that prompted my contact, Doctor A, to speak out. His claims, made on BBC Southern Counties Radio, not only shocked the hospital trust but led to a quick denial on its behalf. With his identity protected, I asked Doctor A how common medical mistakes were. He replied, "I should think daily is the answer; in fact, I am certain." Were there times when patients' lives were put in danger and not recorded? "I am certain," he replied. With such incidents going unrecorded, he said that investigations into the blunders were not being carried out.

Reporting these claims was not easy. Doctor A knew both the consultant anaesthetist suspended after the fatal mistake at the hospital and nursing staff who were on duty in the operating theatre. Not only did I have a responsibility to protect him, but, having almost no medical knowledge, I needed to trust everything he said. Putting the incident into context was vital. The operation was a major procedure, with the highest mortality-morbidity rate at the hospital. The patient was elderly (74), which increased the risk of things going wrong. I was also told that the error was made during a crisis, and, rather than a drug being administered incorrectly, it was the wrong drug that was given. Instead of a plasma expander being given, an anaesthetic, bupivacaine, was injected intravenously. This contradicted the information that the trust had released to the media—that bupivacaine should have been injected into the spine instead of the vein.

Doctor A was prepared to go out on a limb and say mistakes were happening daily in hospitals throughout Sussex and that it was the skill of doctors and surgeons which prevented these becoming fatalities. Unreported and uninvestigated medical accidents could continue without patients or the public knowing. Charles Turton, medical director at Brighton Health Care, assured the public that clinical errors were not an everyday occurrence, but Doctor A stands by his claim.

Alison Harper *Brighton and Hove reporter, BBC Southern Counties Radio*

WEBSITE OF THE WEEK

Empowering consumers The customer may be king in the retail trade, but in medicine only the most well educated and persistent approach royal status. For most, the gulf between "them" and "us" remains large, and the much vaunted movement to treat patients as partners remains more honoured in the breach than the observance.

But the tide is turning, and this week the *BMJ* presents encouraging UK data (p 517) to suggest that consumer involvement in the design and conduct of clinical trials is increasing. The study concludes by saying that a consumer-led electronic guide to running good controlled trials is needed and that consumer influence should be mobilised.

Serving patients' interests and canvassing more information about what those interests are is exactly what the new Cochrane Consumer Network website is about (www.cochraneconsumer.com). Launched a couple of weeks ago, this site is likely to prove an incredibly useful (free) resource for patients and, I suspect, many of their doctors. The visual appeal of the site may be more Cochrane than consumer, but it provides both short readable summaries of Cochrane reviews as well as, via www.clinicaltrials.gov and www.trialscentral.org, enough information about clinical trials to satisfy even the most assiduous of inquirers.

After becoming well versed in the science and rationale of clinical trials, someone caring for a relative with, say, Alzheimer's disease can, within a couple of clicks, become equally well briefed about the 22 ongoing clinical trials that are currently recruiting patients. The site also provides links to other evidence based healthcare sites, reputable sources of consumer health information, government health reports, and, most importantly, the skills needed to track down good information. Awareness of what the site's press release describes as "access to the kinds of information that only doctors have traditionally found easy to get" should ensure that potentially useful consumer feedback should not be long in coming.

Tessa Richards
BMJ
trichards@bmj.com

PERSONAL VIEW

See pp 501, 517, 548, 562

How the Atlantic barons learnt teamwork

Bored and having been awake through jet lag from 3 am, I turned on the TV in my hotel room in Denver. I had arrived the day before and would that day leave for London: a routine trip for an airline pilot. A rather handsome man appeared on the screen. It was David Lawrence, chairman of Kaiser Permanente Medical Group, the largest non-profit healthcare organisation in the US, but he was speaking about aircraft crashes. He stated that in the United States from 1950 to 1990 commercial aviation fatalities fell from 1.19 to 0.27 per million departures—an 80% reduction in the face of a dramatic increase in the volume of air traffic. I forgot about breakfast and watched the speech.

Dr Lawrence made six points about standard aviation safety practice. These included statutory reporting procedures, a voluntary (without jeopardy) reporting culture, recurring statutory examinations, systems, safety analysis of data, and the acceptance that pilots will make mistakes. Incredibly Dr Lawrence described how the safety practice norms of the aviation industry were anything but routine in health care.

When I returned to the UK I thought how the safety issues Dr Lawrence was talking about could be shared with medical practice. Despite obvious differences, there are parallels between aviation and medicine. Consider the position of pilots more than a decade ago, before crew resource management (CRM) team skills training and testing were introduced. The captain was basically God. While a humble co-pilot's opinion might or might not have mattered, once promoted to captain, the same individual's view was inviolate. Can you imagine the affront to senior captains' dignity when crew resource training was introduced? They were asked to put aside their hard earned status and accept questioning from "junior" pilots, a shift from autocrat to team player. Yet now, even the most dyed in the wool "Atlantic baron" is convinced of the value of teamwork and of teamwork training—a radical change in culture.

CRM training was developed as it became apparent how team skills, or the lack of them, were key factors in air safety. Too many crashes had been recorded as due to error by the pilot or crew, with all the stigma of blame; and the public, the regulators, pilots' associations, and commercial operators all demanded a deeper investigation into the reasons behind the apparent breakdown of crew working.

The examples are public. A large difference of opinion between the pilots during the let down phase of a Dan Air 727 flight over Tenerife led to all those on board being killed when the aircraft hit a mountain. A Trident stalled over Staines when the leading edge droop devices were retracted at too low a speed, probably because an assertive captain ignored the views of other pilots. There are many other examples. Just as important, good teamwork has been shown to help in avoiding accidents.

The value of CRM training is unquestioned today. Recurring statutory checks and tests include crew teamwork elements in the regular simulator and route check tests for all pilots. Pilots now accept that professional competence in CRM is as important as their technical knowledge and flying ability.

Contrast this with the culture within medicine of finger pointing, reinforced by a blame based malpractice ethos. Moreover, the regulatory and legal environment in which the modern health service operates is remarkably complex and confusing. Yet Dr Lawrence explained that in the US few healthcare organisations had begun to use human factor and safety system engineering or provided safety related training for their clinicians. Today's NHS has no formal team skills training or goes anywhere near adopting the safety procedures that work in aviation.

> The experience of aviation shows that we can help the NHS understand safety problems

Medicine embraces an expectation of perfect performance, even though the evidence clearly argues for a different conclusion. This reinforces the culture of individual blame and increases the difficulty of putting team skills training in place. The experience of aviation shows, however, that we can move away from the horror stories to help NHS staff understand the problems of safety, why disasters happen, and how we can make improvements to our behavioural practices. The first steps are to understand, firstly, that accidents nearly always occur because of system failures (human or otherwise), not malice, stupidity or incompetence, and, secondly, that to understand why an accident has occurred usually requires tough analytic endeavour.

Clinical governance is a stride in the right direction but not enough by itself. Training in behaviour that promotes safety is as important as, and complementary to, reactive analysis after the event. I believe medicine can learn something from crew resource management training. And if you feel that such training is something for the nursing staff but not for you then maybe you need teamwork training most of all. I know, I've been there.

Competing interest: DJ is a founding partner of TEREMA, a group of pilots and doctors who run courses on team resource management (01481 7241441, 0802 225835).

David Johnson *senior route check captain, British Airways*

SOUNDINGS

How to be a health secretary

So the general election is over and you are the new secretary of state for health. Welcome to the best job in the cabinet. You will be advised by some of Britain's brightest young sociology graduates, who will help you draw up your plan for revolutionising health care.

Other cabinet posts carry responsibilities. Defence secretaries, for example, have been known to resign over mistakes. With health, however, like transport and prisons, public expectations are so low that this question does not arise.

A major part of your job is to keep them low. Health economists will help you do this. You need not talk to them. Nobody else does. Just let them continue telling everyone that the demand for health care is infinite, so nobody—least of all you—can be expected to supply it.

Never suggest that hospitals adopt rational business practices, such as planned replacement of equipment. On no account talk to people who see patients. Instead, praise them with half-hearted platitudes. This always unnerves them.

Never criticise nurses, midwives, or porters. Take every opportunity to refer, in sentimental but non-sexist language, to their selfless dedication. This creates the right conditions to underpay them.

Never underestimate the tolerance of the public. Voters who readily give money to famine and earthquake relief in developing countries will not raise a murmur in protest when you strip those countries of doctors and nurses.

Criticise senior doctors as much as you like. This is a tradition started by Aneurin Bevan. Indeed, it is the only tradition of his that you are expected to maintain. Don't worry about the profession's response. At any given moment it has at least three dozen leaders, all of whom dislike one another much more than they dislike you.

People are always interested in their health, and the healthier they are, the more they complain. You are their spokesperson. Let's face it: nobody really expects you to know anything about the health service.

A country in which half a million people die each year (mostly of old age) provides lots of human tragedies, many of which you can exploit for political ends. With skill, you could be the first health secretary in decades to advance your political career. Good luck.

James Owen Drife *professor of obstetrics and gynaecology, Leeds*